New England Deaconess Hospital

pulse

185 Pilgrim Road, Boston, Massachusetts | Volume 37 — Number 3 | May/June 1984

Commitment and caring — volunteers at the Deaconess

Volunteers play many roles at the New England Deaconess Hospital. They may be found in the Farr lobby, giving information to patients and visitors; in the patient units, visiting or transporting patients to their appointments; in laboratories, helping with research work; or in offices, stuffing envelopes or maintaining records.

Some of the most visible volunteers work directly with patients — helping in the admitting area, escorting patients to their rooms, or adding a special presence on patient floors and in treatment areas. "When volunteers bring around the book cart or the arts and crafts cart," says Phyllis Wasserman, director of Volunteer Services, "they also take the time to visit with the patients. This can be particularly important for those whose homes are not close by and do not have friends or relatives in the area."

Eileen Farrell, a retired public health nurse, volunteers once a week in Radiation Therapy. "I spend time with the patients while they are waiting to see the doctor or have their therapy," she says. "Some of them like to chat. Others may not be talkative, but they just like to have someone with them — to let them know someone cares."

When possible, Farrell keeps in touch with the patients she meets, visiting them in their rooms or when they return for additional treatments. "I chose to work here because I thought it was an area that some people might back away from," she says. "But the patients are so courageous and have a very realistic approach to their illnesses. I enjoy my work with them and feel it is very worthwhile."

Some volunteers work in the Blood Bank, recruiting and screening donors. Others help out in Physical Therapy and the Pharmacy. The weekly "coffee and conversation" sessions for cancer patients and their families are organized by a volunteer.

Student volunteers, Barbara Dyer (left) and Karen Mobley chat with Maureen Clougher, unit secretary, before delivering flowers to patients on Farr 3.

"There really is no 'typical' Deaconess volunteer," says Wasserman. "They range from high school students to retired people. Some of them have part-time jobs; quite a few are people who are between jobs or changing careers. Some are looking

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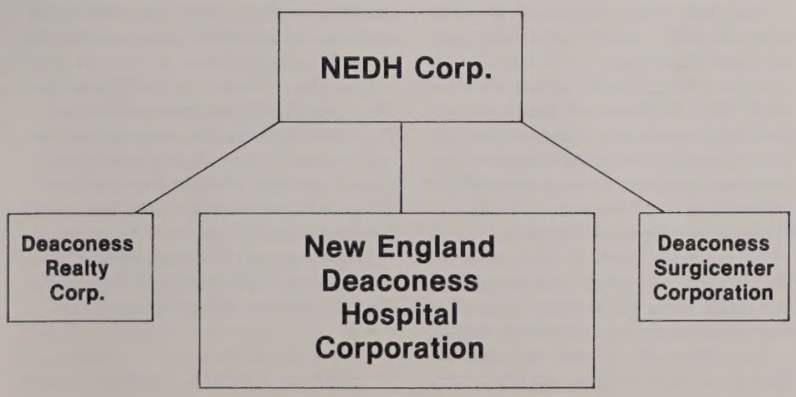
Corporators approve reorganization

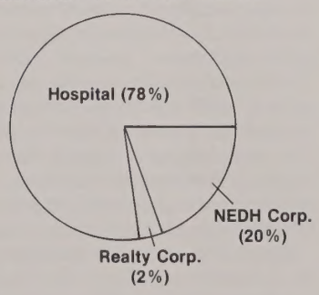
On April 24, the corporators of the New England Deaconess Hospital approved a plan for corporate reorganization of the hospital. This reorganization will enable the hospital to use its existing resources more efficiently and respond more readily to future opportunities, but will not affect any of the hospital's patient care, education, or research activities.

The reorganization, which became effective April 25, converts the existing hospital corporation into NEDH Corp. — a private, non-profit holding company — and establishes three subsidiary corporations: the New England Deaconess Hospital Corporation, the Deaconess Realty Corp., and the Deaconess Surgicenter Corporation. Other subsidiaries may be created in the future.

The holding company will direct and coordinate the subsidiaries. It will be governed by a Board of Directors, whose members are the existing hospital corporation's trustees.



Allocation of current assets



All current hospital activities will be carried out by the non-profit New England Deaconess Hospital Corporation. Medical staff privileges and the status of all employees will remain unchanged.

The Deaconess Realty Corp., a for-profit company, will own and manage non-hospital-related real estate previously owned by the hospital — such as the gas station at the corner of Brookline Avenue and Francis Street, the block of retail stores on Brookline Avenue, and the 306 Riverway apartment building.

The non-profit Deaconess Surgicenter Corporation will hold a partnership in an ambulatory surgery facility to be operated in conjunction with the Faulkner Hospital and Med-21, an investor-owned surgicenter company. Actual establishment of the surgicenter requires the approval of a Determination of Need application by the state Department of Public Health.

Among the advantages of corporate reorganization are easier access to possible affiliations with other hospitals, improved prospects for capital formation, and the expansion of services to include such components as an ambulatory care center or a nursing home.

"Reorganization will result in no change in the day-to-day operation of the hospital," says President Laurens MacLure. "Rather, it represents a recognition that our 'business' has grown from the traditional provision of inpatient care to include many other aspects of health care. The new corporate structure gives us greater flexibility to respond to the challenges of the future, but our overall goal of providing the best possible care for our patients remains unchanged."

Renovations to provide more comfortable, welcoming lobby

"The image patients receive as they first enter the hospital is the most important image they will receive while they are patients," says Gail Graham, Deaconess interior designer. "We want that image to be positive and caring. So, on the advice of the Patient Satisfaction Committee, we decided to renovate the Farr lobby — to give it a more welcoming appearance."

The Patient Satisfaction Committee, whose members are the hospital's five associate directors — Peter Campisano, Paul Earle, Ellen Howland, R.N., David Lilley, and Roger Perry Jr. — was organized in late 1982 to develop a consistent method of handling patient dissatisfaction and to begin programs to enhance patient satisfaction. The committee's patient questionnaire — given to every fifth patient discharged from NEDH — helps members to identify the trends in patient satisfaction in many areas of the hospital.

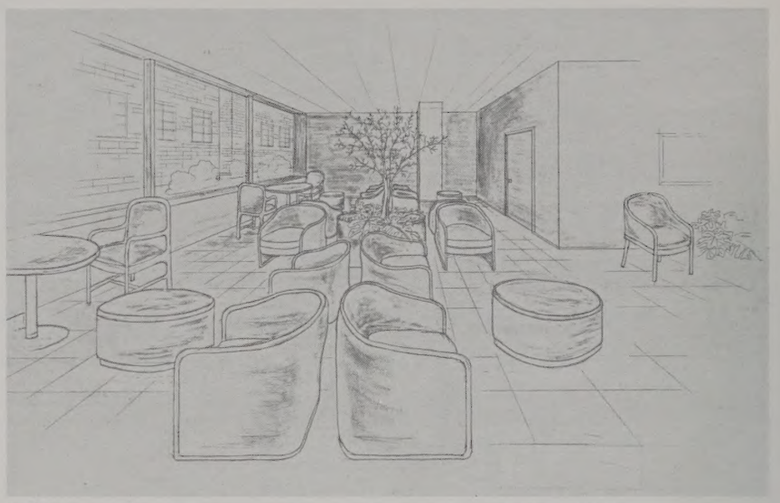
Says Campisano, chairman of the committee, "Based on patient comments we'd received, and on our own observations, we decided that a lobby renovation would be our next project. When the Friends of the Deaconess donated $50,000 to the hospital for the project, we went ahead with it."

Work on the lobby is scheduled to begin in May, starting with the installation of a new rooftop heating and air conditioning unit, providing better temperature control in the lobby in all seasons. A revised air flow system will direct air flow from the lobby toward the vestibule between the two sets of entry doors, keeping the indoor temperature more constant by preventing outdoor air from blowing in.

Hubert Sycamore, assistant director, says, "It's a tough challenge trying to keep the lobby at a comfortable temperature when the doors are constantly opening and closing, letting hot and cold air in. But we think that by forcing air out of the lobby, the temperature will remain at a more comfortable level."

When the heating and air conditioning system installation is completed, redecoration of the lobby interior will begin. A seating area will be situated to the left of the entrance, with several chair groupings and tables for writing. Public telephones and an open display area — with space for newspapers, magazines, and informational brochures — will be located to the right of the entrance.

The space where the telephones are currently located will be converted to a Quiet Room. Says Graham, "The addition of a Quiet Room will afford a place where doctors can talk with patients' relatives in private, or where visitors can just go and be alone." The door to the doctor's lounge will be moved from Farr 1 to Baker 1, making the area less heavily trafficked, further increasing visitor privacy.



Artist's rendering of the new seating area in the redecorated Farr lobby.

A Lobby Task Force, chaired by Graham, was set up to oversee the renovation project. Members of the task force — Nancy Preble-Barrett, an outside interior designer; Eleanor Lowry, Patient Relations; Mary Eliza McDaniel, Friends of the Deaconess; Jeanne Peterson, Service Coordination; Barbara Stank, Building Services; and Tom Wright, Purchasing — chose to redesign the lobby in a "transitional motif."

A new information desk, made of mahogany with brass trim, will extend to the pillar in front of the Coffee Shop. A large "Information" sign will hang above the desk, and there will be wheelchair storage space on the side of the desk facing the Coffee Shop. The walls will be papered with an off-white grasscloth, which, along with new lighting fixtures, will make the lobby appear much brighter.

Smoke green carpet will cover the floor in the seating area, and the windows and chairs will be covered in fabrics in shades of smoke green and mauve.

The Lady of the Lamp stained glass window will be moved from its spot on Palmer 1 to a place on the wall behind the Information Desk, and will be lighted from behind. Says Graham, "That stained glass window is the symbol of our hospital. It represents our long-standing tradition of caring, and it should be in a place where everyone who enters can see it."

Some of the furniture now in the lobby will be moved to the area outside the peritoneal dialysis room on Palmer 1, providing a place where dialysis patients and visitors can relax; it may also be used by employees on breaks.

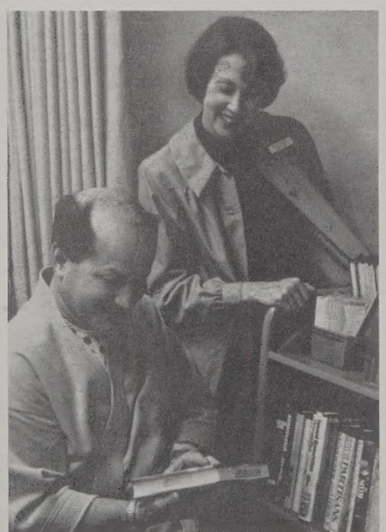
Graham expects the renovations to be completed before the end of the summer. She says, "When we have finished all of our work, the lobby will look very, very different. The new first impression patients will have is one of warmth and friendliness. And that's what we want."

Volunteers *(continued from page 1)*

for experience in the health care field."

Student interns — both high school and college — are a growing volunteer group. Barbara Dyer and Karen Mobley, seniors at Mission High School, work in the messenger service, transporting patients or delivering mail and flowers. Both are interested in nursing careers and came to the Deaconess through a school program requiring every senior to do volunteer work in an area related to his or her career goals.

"Working here gives us a chance to relate to patients for the first time," says Mobley. "Before, I had a few doubts about whether I really wanted to be a nurse. Now I can't wait to get into nursing."



Volunteer Nancy Harrison (right) helps patient Walter Kelley make a selection from the book cart.

Steve Samolyk, a biology major at Boston College, volunteers in the surgical metabolism lab of George Clowes, M.D. Samolyk came to school in Boston particularly to have an opportunity to work in a hospital research lab. "Volunteering here is a great experience," he says. "Dr. Clowes is doing interesting and important work studying factors related to the body's healing after surgery. I'm participating in experiments and in group meetings with doctors, technicians, and outside consultants. It's really an ideal situation for me."

Many volunteers are members of the hospital's auxiliary, the Friends of the Deaconess, which runs the Gift Shop and Thrift Shop, supplies the arts and crafts cart, and raises money for the hospital and the School of Nursing. Others may be former patients, members of patients' families, or retired NEDH employees. "We have a close, special relationship with the Friends," says Wasserman; "and many former patients and employees are very committed to the Deaconess as volunteers."

No matter who they are, volunteers are an essential part of the Deaconess. "Volunteers are an extension of the outside community into the hospital," says Wasserman. "They add an extra dimension to our patient care."

Deaconess offers physician referral service

Choosing a physician is an important decision — one that should not be made in a hurry.

It may be necessary to determine what kind of doctor — family or general practitioner, internist, or other specialist — would be most appropriate. Details such as whether the office hours and location are convenient, whether the doctor is available after hours or in case of emergency, and what arrangements are made when the doctor is out of town should be considered as well.

It is important to take the time to find a physician whose judgment is trusted, in whom there is a feeling of confidence, and who takes an interest in patients as people.

One place to start is the Deaconess Physician Referral Service. The Physician Referral Service can advise callers on the type of physician they should see and provide the names of three staff physicians in the appropriate specialty.

The Physician Referral Service is available at (617) 732-8006, Monday through Friday, from 8:30 a.m. to 5 p.m.

AIDS research and treatment at the Deaconess

AIDS (Acquired Immune Deficiency Syndrome) is described by the U.S. Centers for Disease Control (CDC) as a phenomenon in which a previously healthy individual develops an unusual infection by an organism that is not usually infectious if the immune system is intact, but can be highly infectious if the immune system is impaired. These organisms include *Pneumocystis carinii,* an unusual pneumonia; unusual forms of tuberculosis which are not normally infectious; and a rare skin tumor, Kaposi's sarcoma. To date, there is no known cure for AIDS.

Victims of the disease may experience symptoms related to infections — such as fevers, night sweats, shortness of breath, weight loss, and diarrhea — or may notice the appearance of reddish-purple spots distributed all over the body. AIDS is thought to be transmitted through intimate sexual contact or contact with the blood of an AIDS patient. The incubation period is believed to be between eight months and three years, and the long-term mortality rate approaches 100 percent.

Those at high risk for AIDS include sexually active homosexual and bisexual men, intravenous drug abusers, hemophiliacs, recent Haitian immigrants (for unclear reasons), and heterosexual partners of AIDS patients. The vast majority of the 3,500 identified AIDS cases to date have been found among these categories. Only 64 AIDS cases have been people not in any of the high-risk group. Of those, 18 had received a blood transfusion in the previous five years, yet only six of those 18 cases involved a donor identified as being at risk for AIDS.

During the past six months there has been a 95 percent increase in the number of AIDS patients in the United States. The spread of the disease is similar to that of viral illnesses transmitted through intimate contact or contact with contaminated blood. Current research on the cause of AIDS focuses on viruses that affect T-lymphocytes, the cells that make various proteins important to the immune system. These cells are missing or reduced in AIDS patients.

Joan Kinniburgh, R.N., oncology nurse, supervises the infusion of gamma interferon, an experimental antiviral treatment, in a group of AIDS patients.

Deaconess physician Jerome E. Groopman, M.D., a prominent AIDS researcher, works in collaboration with researchers at the CDC in Atlanta; Max Essex, Ph. D., at Harvard University; John Sullivan, M.D., and Carel Mulder, Ph.D., at the University of Massachusetts Medical Center; and Robert Gallo, M.D., at the National Cancer Institute. Groopman's research is centered in two areas: developing diagnostic tests by performing virologic and molecular biologic analysis of tissue; and developing treatment protocols for the disease. He also assists in efforts to determine what viruses might cause AIDS by providing patient material such as tissue specimens to molecular biologists at Harvard Medical School, the University of Massachusetts Medical Center, and the National Cancer Institute.

Funds for Groopman's research come from a variety of sources. Certain industries interested in developing therapies or diagnostic tools for the disease support research, and grants are also received from such organizations as the American Cancer Society. Groopman now is a member of the Governor's Task Force on AIDS, which is seeking $1.5 million from the state legislature to support medical research and emotional support programs like the AIDS Action Committee.

"A group of good Samaritans" who work for AIDS patients, the AIDS Action Committee volunteers help patients with social work concerns, deliver meals, provide transportation to their physicians, and even go shopping for them. It is a comprehensive hospice program for the very ill and provides psychological and emotional support for those patients who are still relatively healthy.

Emotional support may held AIDS patients deal with the psychological effects of the disease, but it cannot help in treating the physical effects of AIDS. "The real key in treating AIDS patients is to reconstitute the immune system" says Groopman. One of the most widely-used treatments for the disease today is interferon, which fights viruses, stimulates the immune system, and has an overall anti-tumor effect. Patients at UCLA Medical Center were treated with alpha interferon, which caused some tumor regression, but no real change in the immune system. Gamma interferon, derived from T-lymphocytes, now is being tested, and NEDH is the first center in the country to use genetically engineered, highly purified gamma interferon to treat AIDS patients. Interleukin 2, a growth hormone for T cells is being tested at the National Institutes of Health in Maryland. Many other experimental treatments have been tried, but none have been successful.

AIDS patients are treated as outpatients and inpatients at hospitals across the state, including the Deaconess. Says Groopman, "There is a tremendous amount of fear and anxiety about the disease, but at this stage it shouldn't keep us from delivering good care to these patients. The precautions that currently exist at hospitals everywhere are rational and do protect health care workers and others from getting any disease" (see accompanying story).

"I cannot emphasize enough the incredible human tragedy of this disease," Groopman says. "Fifty percent of the patients are between the ages of 30 and 40, and many of them are dying. These are people who have been discriminated against for one reason or another in our society — or, in the case of hemophiliacs, have been chronically ill. Then they get a devastating disease that is generally terminal and has many serious complications. It's a tough business."

Infection Control Committee sets AIDS precautions

Although there have been no incidents of health care workers contracting AIDS through their professional activities, hospitals including the Deaconess have established specific precautions to protect their employees from possible infection. Guidelines set up by the NEDH Infection Control Committee and based on the recommendations of the Centers for Disease Control vary depending on the individual patient's condition and the degree of contact with employees.

Julie White, R.N., nurse epidemiologist, says, "The minimal guidelines for AIDS include wearing gloves when handling blood and body fluids. If employees are doing procedures where they have a greater risk of exposure, they put on gowns or even masks."

"We follow many of the same precautions as are used for Hepatitis B, which is the clinical model that we use for AIDS," says White. "In addition we put AIDS patients in private rooms, for a number of reasons. Sharing a room could have some strong psychological implications — for the patient as well as for the roommate. We also need to protect the AIDS patient from infections that could be carried by other patients or staff members, and it's easier to do that in a private room."

Blood samples and other lab specimens are labeled as "biohazards" and are handled with special care in the labs and the blood bank. "We just follow the principles of common sense and good hygiene," says Walter Dzik, M.D., medical director of the blood bank.

Additional precautions are taken in the blood bank to prevent the possibility of transmitting AIDS in blood products, although as Dzik notes, "the relationship between blood transfusions and AIDS is a very, very minor aspect of the disease." Potential donors are given information on AIDS and anyone in a high-risk group is asked to refrain voluntarily from donating.

"People in high-risk groups have been very cooperative in relieving the concerns of the rest of society by just voluntarily dropping out of the donor pool" says Dzik. "Unfortunately, healthy people have stopped donating blood as well because they have the impression that they could contract AIDS by donating blood. This has caused a real problem with the national blood supply. But there is absolutely no way anyone can contract AIDS by donating blood."

To provide employees and staff with information on AIDS treatment and precautions, AIDS researcher Jerome Groopman, M.D., has delivered Medical Grand Rounds and spoken to the nursing staff on the subject. White has met with representatives from the laboratories, radiology, housekeeping, and maintenance to answer their concerns.

"Unfortunately, some of the media have sensationalized the AIDS issue and caused people to become very nervous," says White. "We know it is a disease to be concerned about, and it's probably much more terrifying to the lay person because of the high mortality rate and the psychosocial implications. The committee is working to maintain a calm, rational approach to the issue and to serve as an information resource to eveyone in the hospital."

Anyone with questions about AIDS precautions should contact Julie White, R.N., nurse epidemiologist, at 2-8493.

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PULSE is published by the Public Relations Department, New England Deaconess Hospital, 185 Pilgrim Road, Boston, Massachusetts 02215, telephone (617) 732-8046. Third class postage paid in Holliston, Massachusetts. Permit (nonprofit organization) No. 18.

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AIDS Update

On April 23 Secretary of Health and Human Services Margaret Heckler announced that a team of researchers headed by Robert Gallo, M.D., of the National Cancer Institute (NCI) had identified the cause of AIDS — a virus called HTLV-III. Heckler said that a blood test for AIDS should be available within 6 months and a vaccine could be developed in 2 years.

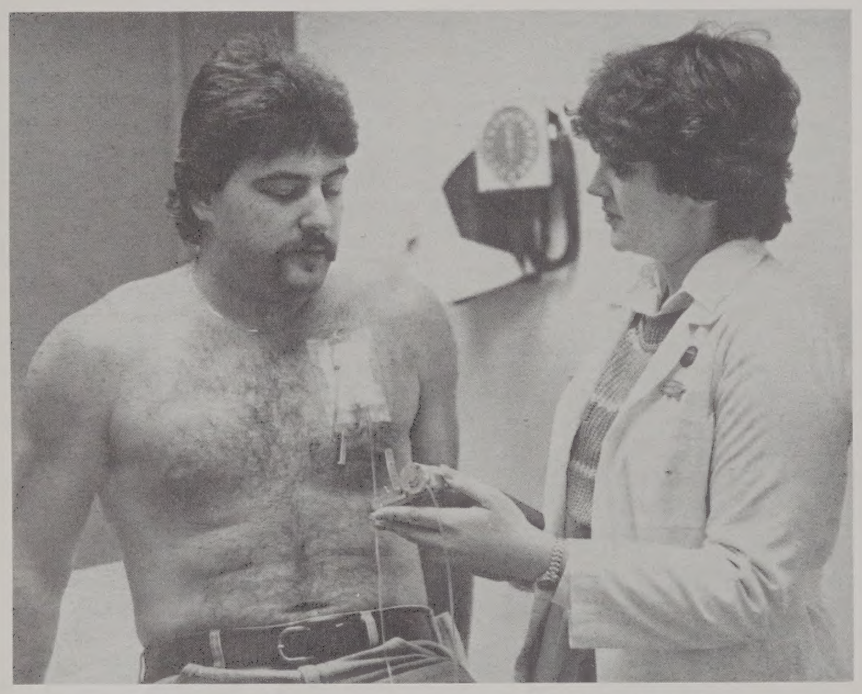
Materials provided by NEDH to the NCI have contributed in part to these important developments. Further progress in AIDS research and treatment will be reviewed in future issues of PULSE.

NEDH offers improved method of cancer treatment

Chemotherapy has been an effective cancer treatment since Sidney Farber, M.D., first demonstrated its usefulness more than a generation ago. Over the years, chemotherapy has been refined to reduce some of its unpleasant side effects and increase its efficacy. One of the more recent advances involves the method of administration of chemotherapeutic drugs, a procedure called infusion chemotherapy.

Experiments with infusion chemotherapy were performed at the Deaconess in the early 1960's, but a formal program was not initiated until 1980. Currently the Deaconess is the only hospital in the country routinely administering infusion treatments.

Traditional chemotherapy is based on the principle that destruction of a tumor cell requires a high drug dose — the higher the dose, the more cells killed. With this method, a rapid or "bolus" injection is administered over a period of 15 to 30 minutes, resulting in a high peak and sharp drop in drug concentration; this is one of the reasons chemotherapy patients often experience nausea and vomiting. Chemotherapy drugs are rapidly metabolized and excreted from the body, and affect cells for only a short time. Yet at any one time, only a small number of tumor cells are in a phase of their growth when they are vulnerable to the effects of the drug.



Patient Francis Duggan, (left) reviews the operation of his external infusion pump, which delivers chemotherapy with fewer side effects, with oncology nurse Martha Franklin, R.N.

Infusion chemotherapy — an alternative to bolus chemotherapy — involves continual, low-dose drug exposure for specified periods of time: days, weeks, or in some cases months, depending on the individual. This method can reduce the size of tumors, and the absence of a high peak of drug concentration eliminates nausea and vomiting.

Jacob J. Lokich, M.D., chief of oncology in the Department of Medicine who initiated the infusion chemotherapy program, says, "With almost every disease in the field of medicine — arthritis, diabetes, hypertension, and infections — treatment involves continual exposure of the patient to agents that maintain therapeutic blood levels. It's only rational to assume that one would increase the effectiveness of cancer treatment delivered in this way."

Chemotherapy drugs are administered either through regional (high doses delivered directly to the affected organ) or systemic (low doses distributed throughout the entire system) infusion.

When a patient receives regional infusion, a thin tubing (called a catheter) is inserted into an artery, and guided by X-ray to the main artery serving the affected organ. With systemic infusion, the catheter is inserted into the vein under the collar bone, which returns all of the blood from the upper part of the body to the heart. This catheter may be outside the skin on the chest wall or connected to a small disc that acts as a drug reservoir and is implanted under the skin.

A further refinement of systemic infusion involves putting a catheter directly into the abdominal cavity. Says Lokich, "We can now infuse into the abdominal cavity, and the drug gets absorbed into the body's system just as if it was sent through the vein. We call this a 'belly bath.'"

With arterial, venous, or abdominal access, a connecting catheter runs from the insertion site to an infusion pump containing a medicine bag. Drugs are pumped into the catheter at a rate determined by the type of drug being administered and the patient's treatment schedule.

Infusion pumps are worn externally — in a shoulder holster or on a belt — or may be implanted under the skin. The external pump, weighing about two to three pounds, contains a rechargeable battery and a drug bag which must be changed once or twice a week. The implanted pump is gas-driven and requires injection of a drug into the pump every two weeks.

Karen Erikson, R.N., oncology team leader, says, "One of the most difficult adjustments patients have to make to infusion is the change in body image. Many people find it difficult to adjust to wearing a pump because they don't want people to know that they are getting an ongoing treatment. That's especially hard because the pump is visible. But we have patients who have adjusted so well to wearing the pump that they almost feel more awkward when they are not receiving treatment."

Despite the difficult adjustments, most patients who have the option choose infusion chemotherapy because it offers relief from treatment side effects and allows them to spend less time at the hospital.

Francis Duggan, a 27-year-old patient who has had several tumors surgically removed, says, "I chose infusion chemotherapy this time because with my previous treatments, I was out of work for a month or more. The chemotherapy I received made me really sick. I just started a new job that's very important to me, so when Dr. Lokich told me I could have this type of treatment and not miss work, I jumped at the chance."

Lokich says, "The traditional approach in treating cancer patients with chemotherapy was to try to minimize their involvement with clinical care. Giving a bolus injection once or twice a month gave them more time at home; that seemed the most compassionate approach to take. But when it became technically feasible for patients to receive infusion chemotherapy from a portable pump that they could maintain at home, it offered a viable alternative to traditional treatment."

Patients receiving treatment at NEDH are taught by members of the oncology nursing staff how to change the medicine bag and batteries in the pump when necessary, and how to change sterile dressings applied at the catheter insertion site.

Erickson says, "The procedures are simplified to help in patient teaching, but you have to have a patient and family who really are committed to continuous infusion. If this is something they don't really want, they're not going to learn."

Duggan and his mother and sister were taught how to maintain the infusion pump and change the sterile dressings. Duggan says, "We spent an entire day just learning how to operate this pump. It's better for more than one person to know how to change the medication bag or how to handle any problems that might come up. We talk each other through everything. It becomes a family affair, and it's brought us all closer together."

Teaching is done through repeated demonstration. Patients receive

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Infusion chemotherapy subject of record-breaking cancer course

The thirteenth annual New England Deaconess Hospital/Harvard Medical School Cancer Course addressed the subject of infusion chemotherapy and drew the largest audience in the program's history. More than 250 physicians, nurses, and other health care professionals — almost 5 times the attendance at previous courses — attended the program held March 1-3.

"We expected a good response," says Robert Pence, administrative director of the Cancer Research Institute, "but so many people registered that we had to move the program from Joslin Auditorium to the Hyatt Regency Hotel in Cambridge. Attendance was excellent, even for the Saturday sessions, which indicates the high quality of the presentations."

According to Jacob J. Lokich, M.D., chief of oncology and director of the course, there are a number of reasons for the program's popularity. "The current approach to chemotherapy has had limited effectiveness," he says, "and many people are looking for better ways to treat cancer patients. In addition there is a great deal of awareness of and enthusiasm for the new technology in chemotherapy, particularly the implanted infusion pumps."

Lokich also notes that, because this type of treatment involves many aspects of medical care, the program had appeal for a broad range of medical professionals. "Surgeons and radiation therapists are interested, as well as oncologists," he says.

Faculty for the course included members of the NEDH medical, nursing, and pharmacy staffs, as well as guests from the Dana-Farber Cancer Institute, Massachusetts General Hospital, Memorial Sloan-Kettering Cancer Center, the University of Alabama, the University of Chicago, and the University of Virginia.

The NEDH/Harvard Cancer Course is the longest running annual update on cancer care in New England.

New policy changes visiting hours, allows children to visit

Visiting hours for patients at the Deaconess have been modified, and rules regarding visits by children will be changed. Visiting hours for most hospital units are now 11 a.m. to 8 p.m. daily. In the intensive and coronary care units (Farr 6) and the special care units on Farr 3 and Farr 8, visiting hours are every day from 1 to 8 p.m. On Deaconess 4 and Baker 4, visiting hours are from 4 to 8 p.m. weekdays and from 1 to 8 p.m. weekends and holidays.

"Previously, the visiting hours were much more fragmented," says Dorothy Ross, director of marketing and head of a committee studying visiting policy. "They varied widely from floor to floor, and visitors sometimes were confused about which hours applied to the patients they were visiting. In devising the new visiting system, we determined which hours would best accommodate the needs of patients and staff as well as the convenience of visitors."

For the first time children under 12 will be allowed to visit NEDH patients. "We want to make the hospital as pleasant as possible for our patients," Ross says. "Many patients — particularly those who are hospitalized for a long time — would like to be able to see their young children or grandchildren during their stay."

The new policy, which goes into effect June 1, will allow children to visit on most floors on Saturdays, Sundays, and holidays from 2 to 4 p.m. if prior permission has been obtained from the head nurse. On the Farr 10 oncology unit, children may visit only with the permission of the patient's physician. Children will not be permitted to visit in the Intensive and Coronary Care Units on Farr 6.

A number of issues were addressed in deciding to allow children to visit. "Childhood diseases, particularly chicken pox, can be very dangerous to patients with suppressed immune systems," says Julie White, R.N., nurse epidemiologist and a member of the Infection Control Committee. "However, a healthy child creates no greater infection risk than a healthy adult. No one — child or adult — should visit if they are not feeling well," White says.

Another concern was the increased noise and distraction for the nurses that may result from children visiting. "We're aware that there could be problems," says Marge Wiggins, R.N., assistant coordinator of nursing practice; "but we also agree that having children visit can be a great advantage for the patient. Visitors should use common sense in bringing and monitoring their children. Most of our visitors do respect the necessary restrictions and the needs of all our patients."

When potential visitors planning to bring children call to get permission, they will be asked questions about the child's possible exposure to disease. The nurse or doctor will also consider the particular patient's situation — the need for rest, scheduled treatments, and general condition — before deciding to allow a child to visit.

Ross says, "If everyone follows the hospital's guidelines for visitors [see accompanying article], visiting will be more enjoyable for both patients and visitors."

Some guidelines for visitors to the Deaconess

- Observe the hospital's visiting hours and leave promptly at 8 p.m.
- Smoke only in the designated visitor's smoking area (Pilgrim's Korner, Baker Basement).
- Be considerate of the patient's need for rest, and keep each visit short.
- Understand that patients need privacy when a treatment or test must be done during visiting hours.
- Check with the patient's doctor or nurse before bringing food from home, since some patients are on special diets.
- Use the public bathrooms located throughout the hospital, rather than the patient's bathroom.
- Refrain from visiting when ill or showing symptoms of a cold, fever, or rash.
- Obtain permission from the head nurse (from the physician for patients on Farr 10) before bringing children under 12 to visit.
- Refrain from bringing children if they are ill or if they have been exposed to communicable diseases and have not been immunized.
- Be considerate of all patients in the hospital, and recognize their need for rest, quiet, and privacy.

Learning the human side of medicine

Medical students spend years in rigorous training learning the basics of medical science — anatomy, genetics, clinical technique, and so on. They learn to diagnose, treat, and cure hundreds of diseases and illnesses. What they have not traditionally been taught, however, is understanding the whole patient — the emotional as well as physical aspects of illness.

Georgiana White, coordinator of medicolegal studies at Harvard Medical School (HMS) and Harvard School of Public Health, says, "We feel very strongly that students should have the opportunity to experience the patient's perspective and hear what a patient is saying without having to respond in a clinical way."

To give HMS students an opportunity to view medicine from the patient side, the school began a pilot program studying hospitals' patient satisfaction-centered services. The elective, for-credit tutorial is offered to second-year medical students who have not yet entered the clinical phase of their schooling. Students work closely with the directors of patient relations programs at one of three teaching hospitals — New England Deaconess, Children's, and Massachusetts General — listening to patients' problems and working to solve them. The program is directed by White and William J. Curran, Ph.D., professor of legal medicine at HMS, with the encouragement of Daniel Federman, M.D., dean of students.

The purpose of the tutorial is to help students develop a more humanistic approach to medicine by learning to understand the non-medical concerns of patients in a hospital, and to give students a thorough understanding of hospital organization. Says White, "We want students to know how to solve specific problems within a complex health care institution."

Holly Smith, one of two HMS students enrolled in the course at the Deaconess, says, "I chose to take this course because I wanted to see what kinds of problems patients have that they wouldn't normally discuss with their doctor. It helps me to think of them as people with real problems other than just a broken leg or a diseased lung. I can see how their medical problems affect their whole life."

Smith and Beverly Spencer spend one afternoon each week with Eleanor Lowry, director of Patient Relations, reviewing patient questionnaires, visiting with patients, and investigating complaints. The students have each met with the directors of various patient service departments — administration, admitting, dietary, social service, X-ray — to get a close-up look at the hospital's daily organization and to discuss methods of handling patient complaints. Says Lowry, "The exposure to the humane aspects of patient care is so beneficial to these students. There is so much more to a patient than the physical problem, and it's great that medical students are taking the time to learn about it."

Medical student Holly Smith (left) goes over patient satisfaction questionnaires with Eleanor Lowry, director of Patient Relations.

In one instance, a female cancer patient in the hospital for tests became very upset when a technician mistook her questions for protests. In need of a sympathetic ear, the woman called Lowry, who took the HMS students along to talk with her. The woman — whose husband had died of cancer only a year before — was depressed because she didn't have the loving support from her husband that he had had from her. Talking with Lowry and the students, she said, made her feel that the hospital cared about her feelings.

Participating students meet periodically with course supervisor White. From her, the students gain a perspective on what they should be looking for and a framework for handling a variety of situations. White says that there are plans to ex-

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Chemotherapy

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booklets and a written summary of instructions that outline basic care and solutions to problems that might occur: these include drug leakage at the catheter insertion site, air bubbles in the line, or a dry medicine bag.

Some patients experience side effects. A blood clot might develop in the catheter, temporarily blocking off the blood returning from the involved portion of the body. Patients also may notice redness and itching on the palms of the hands and soles of the feet. Mouth sores are another inconvenience. All side effects disappear with the interruption of treatment.

Says Erikson, "Many patients are eager to start because they have had severe chemotherapy side effects. Others come to us because, essentially, other physicians have given up. We can't guarantee that continuous infusion chemotherapy will work, but at least they see that we sincerely give them hope."

Medical students

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pand the program next year: "We were so encouraged by the students' reactions to the course and by their responses to certain situations they have become involved in that we decided to offer the course to first-year students, and possibly to expand the course to include a few more Harvard-affiliated institutions."

Lowry agrees that an expanded course could prove to be of great benefit to the hospital and its patients as well as the students. She says, "Our main purpose as a hospital is patient care; the teaching and research are supportive to that. Personalized patient care is what makes us different. So if our students and our residents are more caring and more understanding of patients and their problems, that definitely benefits the hospital. Even more importantly though, it benefits the patients."

News in Brief

James S. Chrzan, D.P.M.; Geoffrey Habershaw, D.P.M.; and **Frank J. Stuhr, D.P.M.;** podiatrists, recently lectured on management of the diabetic foot at the Pennsylvania College of Podiatric Medicine.

Paul Earle, chief financial officer, participated in a panel session on cost containment and spoke on strategies for containing health insurance benefits at a seminar coordinated by Corroon and Black of Illinois; the seminar was conducted for business executives concerned with containing health care costs.

Judith M. Farias, R.N., assistant director of the School of Nursing, presented a paper on the results of systemic plans for evaluation of nursing programs at a workshop sponsored by the National League for Nursing Council of Diploma Programs.

Kathleen Grimes, R.P.T., M.S., physical therapist; **Ellen Leary, R.N., M.S.N.,** cardiovascular clinical nurse specialist; and **Jamie Pope, R.D., M.S.,** clinical dietitian coordinated a symposium on rehabilitation after coronary artery bypass surgery, held in March.

Jack Hawiger, M.D., chief of experimental medicine, has been appointed to the executive committee of the council on thrombosis of the American Heart Association. He also was recently invited to serve on the national advisory committee of the Commonwealth Fund Fellowship Program, which encourages minority medical students to pursue careers in biomedical research and academic medicine. At the annual meeting of the American Society of Hematology, Hawiger chaired a session on platelets and presented a paper to a session on thrombosis.

Barbara B. Hooker, R.N., associate director of the School of Nursing, presented a paper to the annual meeting of the National League for Nursing (NLN) Council of Diploma Programs on the NLN's role in accreditation of nursing programs. Hooker is chairman of the NLN committee on accreditation.

Marek Kloczewiak, Ph.D., research associate in experimental medicine, presented a paper on platelet receptor recognition sites at the annual meeting of the American Society of Hematology. At the same meeting, **Sheila Timmons,** research associate in experimental medicine, presented a paper on common receptor mechanism for binding von Willebrand factor and fibrinogen to human platelets.

Jacob J. Lokich, M.D., chief of oncology, presented the Woodward Memorial Lecture at St. Francis Memorial Hospital in San Francisco. He also was elected chairman of Community Clinical Oncology Program investigators for the Gastrointestinal Tumor Study Group.

Ann Lees, M.D., scientific associate, and **Robert Lees, M.D.,** chief of peripheral vascular disease, headed a meeting in San Francisco on the use of mevinolin, a new drug for the treatment of hypercholesterolemia.

Donald G. Miller, M.D., nephrologist, spoke on diabetic complications to the White Mountains Continuous Ambulatory Peritoneal Dialysis Symposium in March.

Eileen C. Miskell, senior accountant, was recently elected a fellow of the Massachusetts Society of Certified Public Accountants.

Anthony Monaco, M.D., scientific director of the Cancer Research Institute, participated in a symposium on organ transplantation at Montefiore Medical School in New York.

Albert L. Sheffer, M.D., chief of allergy, presented a paper on exercise-induced anaphylaxis to the annual meeting of the American Academy of Allergy and Immunology. He recently assumed the chairmanship of the Academy's education council. Sheffer also has been promoted to clinical professor of medicine at Harvard Medical School.

Alumnae reunion day

The 16th Annual NEDH School of Nursing Alumnae Reunion will be held Saturday, October 27. Registration will begin at 8:30 a.m. at Audrey Kennedy Hall, One Autumn Street, Boston, to be followed by the meeting and program. Luncheon will be held at 12:45 p.m. at Valle's restaurant in Newton.

Further information and a registration form will appear in the July/August issue of PULSE.

Moving? We'd like to know.

Because the post office does not forward third-class mail, we need your help in keeping the PULSE mailing list accurate. If you are moving, please inform the NEDH Public Relations Department, 185 Pilgrim Road, Boston, Massachusetts 02215, (617) 732-8046. It would be particularly helpful if you could send your PULSE address label. (NEDH employees should inform their supervisors of changes of address.) Also let us know if you receive more than one copy of PULSE.

AIDS research and treatment

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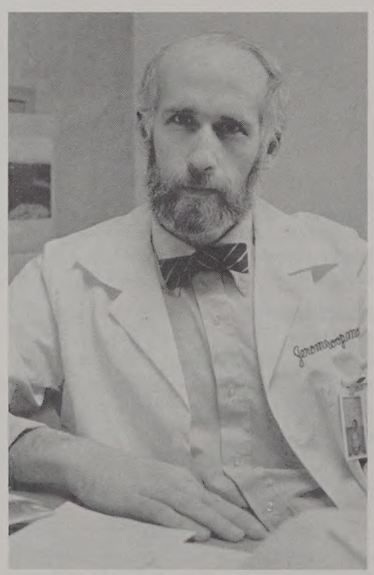

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